Prepared Testimony of Jeff Lemieux
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Passing the Feasibility Test: A Low-Income and Catastrophic Medicare Drug Benefit

Thank you, Mr. Chairman for inviting me. I am very grateful for the opportunity to testify this morning. My name is Jeff Lemieux, and I am the senior economist with the Progressive Policy Institute (PPI) and the executive director for a small new think tank called Centrists.Org .

Background. Before I joined PPI, I was the staff economist for the Breaux-Thomas Medicare Commission in 1998 and 1999.

The Medicare Commission made a simple, but profound proposal: Before considering benefit cuts or tax increases, we should try to slow the growth of Medicare spending through competition and consumer choice.

The Breaux-Thomas competition proposal used the Federal Employees Health Benefits (FEHB) system as a model. This plan was also called "premium support." The Medicare Commission's work resulted in the Breaux-Frist Medicare reform bill, which was first introduced in 1999.

Slouching Toward Reform. I have a great deal of respect for the members and staffers who have worked extremely hard to figure out ways to ease Medicare toward a premium support system. That is very valuable work that will almost certainly be important in the near future.

Moreover, PPI still believes that premium support will ultimately be the best way to reform the Medicare program toward greater competitiveness and cost-savings, benefit flexibility, and clinical improvements.

However, I now believe this is not the right legislation and now is not the right time to enact even a slowly phased-in premium support system. (The House-passed Medicare bill would begin to phase in premium support formulas in 2010.)

Medicare reforms based on competition should be preceded by an extensive national discussion, with full public debate on the pros and cons. Presidential leadership would be required to create that discussion.

I am worried that half measures, put together as a compromise in the conference committee, and not thoroughly considered and evaluated by the public, could actually discredit the larger reform concept. For example, the public might confuse "Medicare

reform" with the drug benefit that is included in both the House- and Senate-passed Medicare bills. The drug benefit is scheduled for implementation in 2006, and it is unlikely to work satisfactorily. Therefore, people might assume Medicare reform had failed (when in fact it hadn't been tried.)

An Unworkable Drug Benefit. The design of the 2006 drug benefit pending in conference was a rare political compromise. However, the result is a tortured policy, which would be very hard to implement. This is a recurring problem in health: reasonable sounding political compromises that may not be good policy.

Problem #1: The Premium. On a political level, it seems perfectly fair to ask seniors to pay a part of the cost of any large new benefit. But a premium of $35 a month (and rising over time) forces each senior to make a choice: Is the benefit worth the premium?

Clearly, seniors with high drug expenses will select the new benefit. To them, the premium would be well worth it. However, seniors with low drug expenses may not see the need. The problem is, if seniors with high drug expenses enroll, and seniors with low costs do not, the premium would be forced higher and the whole benefit could unravel.

To compel most seniors to enroll -- not just those with high drug expenses -- Medicare would impose a penalty: Seniors choosing not to purchase the drug benefit at their first opportunity would pay a significantly higher premium if they tried to enroll later. But this penalty will cause both confusion and resentment among seniors with little need for additional drug benefits.

Problem #2 The Cost. To hold federal outlays to the budgeted $400 billion over 10 years, the benefits are capped: Above the benefit cap, there would be no coverage -- this is the so-called doughnut hole in the benefit. To ease concerns about the cap, Congress added "catastrophic" coverage for seniors whose out-of-pocket drug spending exceeded about $3,500 in a year.

But this particular type of catastrophic coverage would not allow retiree drug benefits from seniors' ex-employers to count toward the Medicare benefit. That exclusion, in turn, gives firms an incentive to drop their retiree drug benefits. Why provide a retiree benefit that doesn't count?

The Congressional Budget Office estimates that employers will cease drug coverage for between 32 percent and 37 percent of their retirees. Other analysts say the number would be lower, at least at first. On the one hand, Medicare would provide subsidies to firms that don't drop retiree coverage. But with the federal budget already in deep deficit, those subsidies may not last. In any event, many seniors with retiree coverage would risk seeing that coverage dropped or reduced.

The decisions to raise the premium, carve up the benefit, and disqualify retiree coverage were made to satisfy a budget constraint. I realize that Congress wanted to preserve the

appearance of a standard, generous drug program, which seniors have come to expect. But to keep the federal cost within the budget, they had to nip and tuck.

A Feasible Solution: The Discount Card Approach. Mr. Chairman, I'd like to congratulate you for working on a zero-premium, low-income, and catastrophic drug benefit, which could be implemented as an extension of the Medicare-endorsed discount card approach already agreed to by the Medicare conferees.

The discount card approach would be both politically feasible and workable in practice. Moreover, it would be compatible with future competitive reforms. Finally, it wouldn't promise a more elaborate benefit than the budget can provide.

The discount card program is now scheduled to be implemented in 2004 as an "interim" measure. The discount cards would be available to all seniors for at most a nominal fee. They would provide discounts of roughly 10-20 percent off the retail price of many drugs.

In addition, low-income seniors could apply for extra assistance through the cards. The cards would provide up to $600 in benefits to seniors with incomes below 135 percent of poverty. The benefits would have a 5 percent copayment requirement for seniors under 100 percent of poverty (10 percent for seniors between 100 and 135 percent of poverty).

These low-income benefits would be added to seniors' discount cards in advance, like a cash card or a Medical Savings Account (MSA).

Instead of switching from the discount cards to a complicated, premium-based drug benefit in 2006, the cards' low-income assistance should be improved by increasing the poverty thresholds and raising the amount of benefits available on the card. Second, a catastrophic benefit should be added for all seniors through the cards.

Fairness to Seniors Who Do the Right Thing. It is wrong to try to target Medicare benefits to people who don't already have drug coverage, for several reasons:

1. Seniors could drop their current coverage to qualify for the new government benefits;
2. Seniors' ex-employers could drop their retiree coverage;
3. It would turn Medicare into a welfare program, not a social insurance program; and
4. It would reward people who never tried to acquire coverage on their own, while penalizing those who did the right thing and tried to protect themselves.

It is more expensive to allow all seniors with low-incomes to qualify for extra assistance, not just those who are currently uninsured. To keep the costs down, the poverty levels may need to be lowered, or the benefit amounts reduced. However, this is worth it, if it preserves incentives for seniors to take care of themselves, rather than creating a welfare-like program where seniors are rewarded for behaving less responsibly.

Catastrophic Coverage for All. I believe social insurance programs should have benefits that are appropriate and fair for all beneficiaries, rich or poor. Certainly catastrophic coverage for the highest drug costs falls into the category of coverage we want all seniors to have, regardless of income.

Moreover, catastrophic coverage for all Medicare beneficiaries would help the program target disease management programs to people with chronic illnesses, and could help Medicare's program for private health plan choices -- now called Medicare +Choice -- work better.

The Right Kind of Catastrophic Coverage. There are two kinds of catastrophic drug benefits: (1) coverage that begins when a senior's "out-of-pocket" drug spending hits a certain limit, and (2) coverage that begins when a senior's "total" drug spending hits a limit, regardless of whether or not the senior had additional drug coverage (from an ex-employer or Medigap plan, for example).

The second type of coverage -- based on a senior's total drug spending -- is preferable, because it would create the right incentives. It would reward people for working to obtain retiree coverage, or saving to be able to afford Medigap coverage. Their efforts would "count" toward the Medicare benefit.

On the other hand, a catastrophic benefit based on out-of-pocket spending would not maintain incentives for seniors to take care of their own coverage. And in the long run, it would not be much less expensive. Over time, seniors and employers would adjust to a catastrophic benefit based on out-of-pocket spending by dropping their outside or retiree coverage, making that sort of benefit almost as expensive as a benefit based on total spending.

A Multitude of Discount Card Issuers. The discount cards should be issued by as many qualified entities as possible: employers with retiree benefits, states, pharmacies, drug companies, pharmaceutical benefit managers, HMOs, and other health plans. This would create a healthy competition, in which card issuers competed to get the best discounts and services for their enrollees.

To reimburse for the low-income and catastrophic benefits, Medicare would pre-arrange performance incentives and accountability measures with qualified card issuers. These expenses would be Medicare's responsibility, and Medicare would audit the card issuers to ensure they were achieving sufficient discounts for seniors and were administering the catastrophic or low-income benefits in an efficient manner.

Conclusion. The main problem with the House- and Senate-passed drug benefits is that they overpromise. It would be better to enact a more modest expansion of the discount card program, adding benefits for low-income seniors and extending basic catastrophic coverage to all. The larger, more complicated drug benefit designs in the House and Senate bills may seem more politically palatable now, but they would likely be very unpopular or expensive if the government tried to implement them in 2006.

Likewise, it would be better to resume the larger debate about Medicare reform at a later date than to allow the reform issue to create an impasse on drug benefits or allow half measures toward reform -- which the public might not sufficiently understand -- to discredit reform concepts before they get a proper chance.

Mr. Chairman, I would be happy to try to assist your continuing efforts toward an alternative Medicare drug proposal, and to answer any questions you may have.